

(d) Ordinarily a provider or supplier is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agency may recommend that additional time be granted by the Secretary in individual situations, if in its judgment, it is not reasonable to expect compliance within 60 days, for example, a facility must obtain the approval of its governing body, or engage in competitive bidding.

[59 FR 56237, Nov. 10, 1994, as amended at 77 FR 67164, Nov. 8, 2012]

**§ 488.30 Revisit user fee for revisit surveys.**

(a) *Definitions.* As used in this section, the following definitions apply:

*Certification* (both initial and recertification) means those activities as defined in § 488.1.

*Complaint surveys* means those surveys conducted on the basis of a substantial allegation of noncompliance, as defined in § 488.1.

*Provider of services, provider, or supplier* has the meaning defined in § 488.1, and ambulatory surgical centers, transplant centers, and religious non-medical health care institutions subject to § 416.2, § 482.70, and § 403.702 [C8] of this chapter, respectively, will be subject to user fees unless otherwise exempted.

*Revisit survey* means a survey performed with respect to a provider or supplier cited for deficiencies during an initial certification, recertification, or substantiated complaint survey and that is designed to evaluate the extent to which previously-cited deficiencies have been corrected and the provider or supplier is in substantial compliance with applicable conditions of participation, requirements, or conditions for coverage. Revisit surveys include both offsite and onsite review.

*Substantiated complaint survey* means a complaint survey that results in the proof or finding of noncompliance at the time of the survey, a finding that noncompliance was proven to exist, but was corrected prior to the survey, and includes any deficiency that is cited during a complaint survey, whether or not the cited deficiency was the original subject of the complaint.

(b) *Criteria for determining the fee.* (1) The provider or supplier will be assessed a revisit user fee based upon one or more of the following:

(i) The average cost per provider or supplier type.

(ii) The type of revisit survey conducted (onsite or offsite).

(iii) The size of the provider or supplier.

(iv) The number of follow-up revisits resulting from uncorrected deficiencies.

(v) The seriousness and number of deficiencies.

(2) CMS may adjust the fees to account for any regional differences in cost.

(c) *Fee schedule.* CMS must publish in the FEDERAL REGISTER the proposed and final notices of a uniform fee schedule before it assesses revised revisit user fees. The notices must set forth which criteria will be used and how, as well as the amounts of the assessed fees based on the criteria as identified in paragraph (b) of this subpart.

(d) *Collection of fees.* (1) Fees for revisit surveys under this section may be deducted from amounts otherwise payable to the provider or supplier. As they are collected, fees will be deposited as an offset collection to be used exclusively for survey and certification activities conducted by State survey agencies pursuant to section 1864 of the Act or by CMS, and will be available for CMS until expended. CMS may devise other collection methods as it deems appropriate. In determining these methods, CMS will consider efficiency, effectiveness, and convenience for the providers, suppliers, and CMS. CMS may consider any method allowed by law, including: Credit card; electronic fund transfer; check; money order; and offset collections from claims submitted.

(2) Fees for revisit surveys under this section are not allowable items on a cost report, as identified in part 413, subpart B of this chapter, under title XVIII of the Act.

(3) Fees for revisit surveys will be due for any revisit surveys conducted during the time period for which authority to levy a revisit user fee exists.

(e) *Reconsideration process for revisit user fees.* (1) CMS will review a request for reconsideration of an assessed revisit user fee—

(i) If a provider or supplier believes an error of fact has been made in the application of the revisit user fee, such as clerical errors, billing for a fee already paid, or assessment of a fee when there was no revisit conducted, and

(ii) If the request for reconsideration is received by CMS within 14 calendar days from the date identified on the revisit user fee assessment notice.

(2) CMS will issue a credit toward any future revisit surveys conducted, if the provider or supplier has remitted an assessed revisit user fee and for which a reconsideration request is found in favor of the provider or supplier. If in the event that CMS judges that a significant amount of time has elapsed before such a credit is used, CMS will refund the assessed revisit user fee amount paid to the provider or supplier.

(3) CMS will not reconsider the assessment of revisit user fees that request reconsideration of the survey findings or deficiency citations that may have given rise to the revisit, the revisit findings, the need for the revisit itself, or other similarly identified basis for the assessment of the revisit user fee.

(f) *Enforcement.* If the full revisit user fee payment is not received within 30 calendar days from the date identified on the revisit user fee assessment notice, CMS may terminate the facility's provider agreement (pursuant to § 489.53(a)(16) of this chapter) and enrollment in the Medicare program or the supplier's enrollment and participation in the Medicare program (pursuant to § 424.535(a)(1) of this chapter).

[72 FR 53648, Sept. 19, 2007]

## Subpart B—Special Requirements

### § 488.52 [Reserved]

### § 488.54 Temporary waivers applicable to hospitals.

(a) *General provisions.* If a hospital is found to be out of compliance with one or more conditions of participation for hospitals, as specified in part 482 of this chapter, a temporary waiver may

be granted by CMS. CMS may extend a temporary waiver only if such a waiver would not jeopardize or adversely affect the health and safety of patients. The waiver may be issued for any one year period or less under certain circumstances. The waiver may be withdrawn earlier if CMS determines this action is necessary to protect the health and safety of patients. A waiver may be granted only if:

(1) The hospital is located in a rural area. This includes all areas not delineated as “urban” by the Bureau of the Census, based on the most recent census;

(2) The hospital has 50 or fewer inpatient hospital beds;

(3) The character and seriousness of the deficiencies do not adversely affect the health and safety of patients; and

(4) The hospital has made and continues to make a good faith effort to comply with personnel requirements consistent with any waiver.

(b) *Minimum compliance requirements.* Each case will have to be decided on its individual merits, and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(e)(1)–(8), in addition to meeting such other requirements as the Secretary finds necessary under section 1861(e)(9). (For further information relating to the exception in section 1861(e)(5) of the Act, see paragraph (c) of this section.)

(c) *Temporary waiver of 24-hour nursing requirement of 24-hour registered nurse requirement.* CMS may waive the requirement contained in section 1861(e)(5) that a hospital must provide 24-hour nursing service furnished or supervised by a registered nurse. Such a waiver may be granted when the following criteria are met:

(1) The hospital's failure to comply fully with the 24-hour nursing requirement is attributable to a temporary shortage of qualified nursing personnel in the area in which the hospital is located.

(2) A registered nurse is present on the premises to furnish or supervise the nursing services during at least the daytime shift, 7 days a week.